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	15G225	A. BUILDING 00 B. WING	01/08/2013

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OCCAZIO INC	2234 Q AVE NEW CASTLE, IN 47362

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W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: December 10, 11, 12, 13, 14, 17, 21, 27, 2012, January 7, and 8, 2013. Provider Number: 15G225 Facility Number: 000749 AIM Number: 100243360 Surveyors: Susan Eakright, Medical Surveyor III/QMRP Vickie Kolb, Public Health Nurse Surveyor III These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/11/13 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interv 1 of 1 incident of AWOL (Absence without Lea behavior for client #7, the facility failed to ensu outside workshop met client #7's identified supe needs. Findings include: The facility's records were reviewed on 12/11/1 11:15 AM. The facility's BDDS (Bureau of Developmental Disabilities Services) records in on 6/15/12 at 12:40 PM while at the workshop c "was not at his workstation." The report indicate "trainer checked the bathrooms, all of the main workshop floor, Hab rooms and the outside peri the [name of workshop]. [Client #7] could not b Then four [name of workshop] staff started an o grounds search for [client #7]." The report indic client was located at 12:52 PM at a local grocer The client was persuaded to get into staff's car a return to the group home. The report indicated t were to continue 15 minute checks per client #7 Behavior Support Plan. The BDDS Follow up report of 6/21/12 indicate will future elopements be prevented? [Client #7 on 15 minute checks. This behavior is addressed behavior support plan. We have had a meeting v workshop staff and we will give [client #7] extr around holidays."	W0120	**W 120 Services Provided with Outside Sources** The facility must assure that outside services meet the needs of each client. **1. What corrective action will be accomplished?** · Client #7's behavior plan will be revised to include 15 minute checks due to his supervision concerns. · An AWOL risk plan will be developed for Client #7. · An IDT will be held with workshop on 1-30-13 for Client #7 to discuss his need for supervision while at work. · Client #7's IPOP assessments will be revised to reflect his supervision needs. · Client #7's behavior plan will be revised to include elopement as a targeted behavior.	02/07/2013

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	On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From 10:35am until 12noon, client #7 walked into and out of the workshop area, walked into and out of the break area, and walked from one classroom to the next classroom. Client #7 walked into and out of offices in the front area of the workshop and the lobby area. During the period from 10:35am until 12noon client #7 was not monitored by the workshop staff to prompt him to activity or monitoring client #7's location within the workshop. At 11:25am, client #7's Workshop Supervisor (WKS) indicated he was waiting for the facility staff to come and check client #7's blood sugar. WKS stated "We check for [client #7's] location every once in a while. If we have not seen him walking around." The WKS indicated no documented 15 minute checks were available for review. On 12/12/12 at 10:55am, an interview with the QMRP/PD (Qualified Mental Retardation Professional/Program Director) and the RC (Residential Coordinator) was conducted. The QMRP/PD indicated client #7 should have been monitored every 15 minutes. The RC indicated client #7 should be kept within eyesight supervision. The		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The IPOP assessments for all of the residents will be reviewed and supervision needs updated as necessary. · The supervision needs of all of the residents at the Q Avenue group home will be reviewed with workshop. · The behavior plans for the residents will be reviewed and updated as necessary. · Risk plans for the residents will be reviewed and updated as necessary. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The IPOP assessments for all of the residents will be reviewed and supervision needs updated as necessary. · The supervision needs of	

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	QMRP/PD indicated client #7 was on 15 minute checks because of his unstable blood sugars and non-compliance with his diet. Client #7's record was reviewed on 12/12/12 at The client's IPOP (Individual Plan of Protective Oversight - Residential Information) of 8/17/11 client #7 "has gone AWOL (absent without leav since living in the group home so he must be clo monitored at all times." The 8/17/11 record indi client was on "15 minute checks during hours o and asleep." Client #7's Case Conference Minut 6/18/12 indicated a review of the BDDS report 6/14/12 with no changes made to the client's pla Client #7's 4/2012 Behavior Management Plan did not include documented interventions of 15 monitoring checks. Client #7's 4/2012 BMP inc while in the community client #7 was to be witl eyesight supervision. 9-3-1(a)		all of the residents at the Q Avenue group home will be reviewed with workshop. · The behavior plans for the residents will be reviewed and updated as necessary. · Risk plans for the residents will be reviewed and updated as necessary. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a regular basis while at workshop and daily when in the home. · The Program Specialist will monitor as she completes her audits. **1.What is the date by which the systemic changes will be completed?** · February 7 th , 2013	

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W0130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, for 1 of 1 client (client #7) who had medication administered at the workshop by the facility staff, the facility failed to provide privacy during medication administration. Findings include: On 12/11/12 at 12noon, the facility's Direct Care Staff (DCS) #3 entered the workshop through the front door where client #7 sat at a table in the front lobby area. At 12noon, DCS #3 set down a clear plastic unlocked box on the table in front of client #7 and walked onto the workshop floor area. DCS #3 left the unlocked clear plastic box out of DCS #3's view and client #7's insulin medication (for Diabetes) pen, lancets, and a piece of paper with a documented sliding scale were visibly observed inside the unlocked box. At 12:10pm, DCS #3 returned to the area where she had left the unlocked insulin medication pen and lancets. DCS #3 took client #7's blood sugar by using a lancet to prick client #7's finger, drew blood, and put the blood into the blood sugar reader. DCS #3 set client #7's insulin pen, had client #7 pull up his	W0130	**W 130 Protection of Clients Rights** The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. **1. What corrective action will be accomplished?** · Client #7 will be put on programming to understand the importance of needing his privacy while taking his insulin. · A meeting will be held with workshop on 1-30-13 to discuss the need to encourage Client #7 and staff to administer his medication in privacy. · A staff meeting will be held on 1-30-13 to discuss the importance of ensuring resident privacy when providing treatment and care of personal needs, including insulin administration for Client #7.	02/07/2013

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	shirt, expose his chest, and DCS #3 administered client #3's insulin in the front lobby area of the workshop. Between 12:10pm and 12:20pm, twenty-one (21) people: clients, visitors, staff, and workshop staff entered, exited, and walked through the lobby. No privacy was taught or encouraged by DCS #3. On 12/12/12 at 10:55am, an interview with the QMRP/PD (Qualified Mental Retardation Professional/Program Director) and the RC (Residential Coordinator) was conducted. The QMRP/PD and the RC both indicated client #7 should be given privacy during his medication administration and staff should have prompted him to a closed private area for medication administration. 9-3-2(a)		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · A meeting will be held with workshop on 1-30-13 to discuss the need to ensure privacy when providing treatment and care of personal needs, including insulin administration. · A staff meeting will be held on 1-30-13 to discuss the importance of ensuring resident privacy when providing treatment and care of personal needs, including insulin administration. · The RC will monitor and implement programming for the residents to ensure that they understand their need for privacy during treatment and personal care needs. As their needs change, the RC will ensure that they update their ISP, IPOP's and implement training goals to address the concerns. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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			· A meeting will be held with workshop on 1-30-13 to discuss the need to ensure privacy when providing treatment and care of personal needs, including insulin administration. · A staff meeting will be held on 1-30-13 to discuss the importance of ensuring resident privacy when providing treatment and care of personal needs, including insulin administration. · The RC will monitor and implement programming for the residents to ensure that they understand their need for privacy during treatment and personal care needs. As their needs change, the RC will ensure that they update their ISP, IPOP's and implement training goals to address the concerns. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home and at workshop. · The Program Specialist will monitor as they complete their audits.	

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			5. What is the date by which the systemic changes will be completed? · February 7 th , 2013	

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W0149	**W 149 Staff Treatment of Clients** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **1. What corrective action will be accomplished?** · The RC for the home will be retrained on the importance of notifying the administrator timely and on investigating incidents of unknown injuries, peer to peer aggression, use of restraint and suspected abuse and neglect. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will be trained on how to properly secure wheelchairs using the tie downs in the bus that transports the residents on 1-30-13. **2. How will we identify other**	02/07/2013

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			residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · The RC for the home will be retrained on the importance of notifying the administrator timely and on investigating incidents of unknown injuries, peer to peer aggression, use of restraint and suspected abuse and neglect. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will be trained on how to properly secure wheelchairs using the tie downs in the bus that transports the residents on 1-30-13. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The RC for the home will be retrained on the importance of notifying the administrator timely and on investigating incidents of	

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	Based on interview and record review for 1 of 2 allegations of neglect/abuse for client #2, the facility failed to implement		unknown injuries, peer to peer aggression, use of restraint and suspected abuse and neglect. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will be trained on how to properly secure wheelchairs using the tie downs in the bus that transports the residents on 1-30-13 **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	its Abuse/Neglect policy to immediately report allegations of abuse/neglect/mistreatment to the administrator and to BDDS (Bureau of Developmental Disability Services) in accordance with state law. Based on interview and record review for 1 of 1 injury of unknown origin for client #4, for 1 of 2 allegations of neglect/abuse for client #2 and for 1 of 1 incident of client to client abuse in regards to client #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Based on interview and record review for 1 of 1 investigation reviewed, the facility failed to implement its Abuse/Neglect policy to report the results of the investigation to the administrator within 5 working days in regards to an unknown injury for client #4. Findings include: 1. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated client #2 used an electric wheelchair and would get the wheelchair going too fast, lose control and run into things. DCS #13 stated "a few months ago" while client #2 was on a visit at a lake with his father, the			

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	client was sitting in his wheelchair and ran his wheelchair into the water off of a boat dock. DCS #13 indicated client #2 and his wheelchair were under water and client #2's father rescued both client #2 and the wheelchair from the water. DCS #13 stated client #2 "could have" drowned if his father had not rescued him. The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility records did not indicate an incident of client #2 having to be rescued from the water due to his wheelchair running off of a boat dock with client #2 sitting in the wheelchair. The facility records did not indicate an investigation in regards to client #2 having to be rescued from the water due to his wheelchair running off of a boat dock with client #2 sitting in the wheelchair. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated client #2 used a wheelchair for mobility, was not able to stand on his own and could not swim. The RC indicated he was aware of the incident with client #2 and his father. The RC indicated he did not report the incident to the administrator at the time of the incident nor did he report it to BDDS because the RC did not think it was a reportable incident since client #2 was with his father.			

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	2. The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated: __On 5/27/12 client #4 had a "bruised right eye." The report indicated the origin of the injury was unknown. The record indicated the RC had asked 3 staff if they knew what had happened to client #4. The record did not indicate any client interviews or interviews of all DCS that worked in the home. The facility records did not indicate the results of the investigation had been reported to the administrator. __On 10/18/12 two DCS were taking clients #1, #2, #3, #4, #5 and #6 to the workshop via the facility van. The DCS "heard a big thud" and "realized" client #2 had "fallen over in his wheelchair." The DCS in the rear of the van "got up and went back there to be with him until the other staff found a safe place to pull over." Once the van was stopped, the DCS "had to open up the wheelchair ramp because he (client #2) was wedged in between the ramp and his (client #2's) chair." The report indicated once there was enough room the DCS sat client #2 up and "proceeded to pick him (client #2) up and put him (client #2) back in his (client #2's) chair." The report indicated			

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	the DCS could tell client #2 was not injured "because he (client #2) was laughing" and "did not say he was hurt." The report indicated the DCS then proceeded on to the workshop. The facility records did not indicate an investigation was conducted. __The facility's Bureau of Developmental Disabilities Services (BDDS) records indicated on 5/21/12 "Two male consumers were playing around acting like they were boxing. One of these male consumers asked [client #6] if he would act like his bodyguard and protect him but he was teasing. [Client #6] ripped off his headphones and hit both of the male consumers on their left shoulder with his headphones. One consumer's shoulder was red and the other consumer's shoulder had no red mark." Client #6's arms "were held down one minute until he was calm to prevent him from hitting other clients." The facility records did not indicate an investigation was conducted. Interview with the RC on 12/13/12 at 4 PM indicated all investigations had been provided for review. The RC indicated client #4's injury of unknown origin had been investigated. "I talked to the three staff that were on duty that day." The RC indicated he had not interviewed clients #1, #2, #3, #4, #5, #6 and #7 or all the			

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	staff that worked with client #2 in the group home. The RC indicated he had not reported the results of the investigation of the injury of unknown origin to the administrator. The RC indicated he did not see the need to investigate the incident with client #2 on 10/18/12 because the DCS that were involved told him "one of the buckles must have been unlatched." Interview with the PS (Program Specialist) on 12/13/12 at 4 PM indicated all injuries of unknown origin were to be thoroughly investigated. The PS indicated the RC had not conducted a thorough investigation in regards to client #4's injury of unknown origin. The PS indicated the incident of 10/18/12 "should have been investigated." Review of the 1/1/11 facility policy of "Suspected Abuse, Neglect and Exploitation Reporting" on 12/11/12 at 1 PM indicated: __Employees must report immediately by phone to the RC any incident of suspected abuse, neglect and/or exploitation of a resident/consumer. The RC will report by Internet all allegations of abuse, neglect or exploitation to APS (Adult Protective Services) and the District and Central offices of the BDDS (Bureau of Developmental Disabilities Services) within 24 hours of receipt of suspected			

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	15G225	A. BUILDING 00 B. WING	01/08/2013

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	abuse, neglect and/or exploitation. __All injuries of unknown origin are to be reported to the Director and to be thoroughly investigated. The outcome of the investigation will be reported to the Director within 5 business days. __Neglect to be defined as the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services, including medication errors, are considered neglect when they cause the resident/consumer undue physical or emotional stress or injury. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W0153	**W 153 Staff Treatment of Clients** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. **1. What corrective action will be accomplished?** · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines. · The importance of notifying the administrator immediately will be reviewed with the RC. · The importance of notifying their supervisor and the administrator immediately will be reviewed with the staff at the Q	02/07/2013

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			Avenue group home at the staff meeting on 1-30-13. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · The importance of notifying the administrator immediately will be reviewed with the RC. · The importance of notifying their supervisor and the administrator immediately was reviewed with the staff at the Q Avenue group home at the staff meeting on 1-30-13. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy	

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			regarding abuse, neglect and exploitation. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · The importance of notifying the administrator immediately will be reviewed with the RC. · The importance of notifying their supervisor and the administrator immediately was reviewed with the staff at the Q Avenue group home at the staff meeting on 1-30-13. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a	

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	Based on interview and record review for 1 of 2 incidents of alleged neglect for client #2, the facility failed to immediately report allegations of abuse/neglect/mistreatment immediately to the administrator and to BDDS (Bureau of Developmental Disability Services) in accordance with state law. Findings include: Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated client #2 used an electric wheelchair, would get the wheelchair going too fast, lose control and would run into things. DCS #13 stated "a few months ago" while client #2 was on a visit at a lake with his father, the client was sitting in his wheelchair and ran his wheelchair into the water off of a boat dock. DCS #13 indicated client #2 and his wheelchair		daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013.	

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	were under water and client #2's father rescued both client #2 and the wheelchair from the water. DCS #13 indicated client #2 would have drowned if his father had not rescued him. The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility records did not indicate an incident of client #2 having to be rescued from the water due to his wheelchair running off of a boat dock with client #2 sitting in the wheelchair was reported to the administrator. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated client #2 used his wheelchair for all mobility, could not stand on his own or swim. The RC indicated he was aware of the incident with client #2 and his father. The RC indicated he did not report the incident to the administrator at the time of the incident nor did he report it to BDDS because the RC did not think it was a reportable incident since client #2 was with his father. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W0154	**W 154 Staff Treatment of Clients** The facility must have evidence that all alleged violations are thoroughly investigated. **1. What corrective action will be accomplished?** · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **2. How will we identify other**	02/07/2013

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			residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13.	

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	Based on interview and record review for		· Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	1 of 1 injury of unknown origin for client #4, for 1 of 1 allegation of neglect/abuse for client #2 and for 1 of 1 incident of client to client abuse in regards to client #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Findings include: The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated: __On 5/27/12 client #4 had a "bruised right eye." The report indicated the origin of the injury was unknown. The record indicated the RC had asked 3 staff if they knew what had happened to client #4. The record did not indicate any client interviews, interviews of all DCS that worked in the home or the findings of the investigation. __On 10/18/12 two DCS were taking clients #1, #2, #3, #4, #5 and #6 to the workshop via the facility van. The DCS "heard a big thud" and "realized" client #2 had "fallen over in his wheelchair." The DCS in the rear of the van "got up and went back there to be with him until the other staff found a safe place to pull over." Once the van was stopped, the			

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	DCS "had to open up the wheelchair ramp because he (client #2) was wedged in between the ramp and his (client #2's) chair." The report indicated once there was enough room the DCS sat client #2 up and "proceeded to pick him (client #2) up and put him (client #2) back in his (client #2) chair." The report indicated the DCS could tell client #2 was not injured "because he (client #2) was laughing" and "did not say he was hurt." The report indicated the DCS then proceeded on to the workshop. The facility records did not indicate an investigation was conducted. __The facility's Bureau of Developmental Disabilities Services (BDDS) records indicated on 5/21/12 "Two male consumers were playing around acting like they were boxing. One of these male consumers asked [client #6] if he would act like his bodyguard and protect him but he was teasing. [Client #6] ripped off his headphones and hit both of the male consumers on their left shoulder with his headphones. One consumer's shoulder was red and the other consumer's shoulder had no red mark." Client #6's arms "were held down one minute until he was calm to prevent him from hitting other clients." The facility records did not indicate an investigation was conducted. Interview with the RC on 12/13/12 at 4			

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	PM indicated all investigations had been provided for review. The RC indicated client #4's injury of unknown origin had been investigated. "I talked to the three staff that were on duty that day." The RC indicated he had not interviewed clients #1, #2, #3, #4, #5, #6 and #7 or all the staff that worked with client #2 in the group home. The RC indicated the facility records did not include the findings of the investigation and or the outcome of the investigation. The RC indicated he did not see the need to investigate the incident with client #2 on 10/18/12 because the DCS that were involved told him "one of the buckles must have been unlatched." Interview with the PS (Program Specialist) on 12/13/12 at 4 PM indicated all injuries of unknown origin were to be thoroughly investigated. The PS indicated the RC had not conducted a thorough investigation in regards to client #4's injury of unknown origin. The PS indicated the incident of 10/18/12 "should have been investigated." 9-3-2(a)			

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 1 of 1 investigation reviewed, the facility failed to report the results of the investigation in 5 working days to the administrator in regards to an unknown injury for client #4. Findings include: The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated on 5/27/12 client #4 had a "bruised right eye." The report indicated the origin of the injury was unknown. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated he had not reported the results of the investigation to the administrator in regards to client #4's injury of unknown injury. Interview with the PS (Program Specialist) on 12/13/12 at 4 PM indicated she had not been notified of the results of the investigation in regards to client #4's injury of unknown origin.	W0156	**W 156 Staff Treatment of Clients** The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. **1. What corrective action will be accomplished?** · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy	02/07/2013

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	9-3-2(a)		regarding abuse, neglect and exploitation. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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			practice does not recur: · Staff will be retrained on Occazio's policy #2105 Abuse, Neglect and Exploitation at their staff meeting on 1-30-13. · Staff will retrained on the incident reporting guidelines and the investigation process. · The importance of following the investigation process will be reviewed with the RC. · All staff members who fail to notify the administrator immediately will face disciplinary action per Occazio's policy regarding abuse, neglect and exploitation. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be**	

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			completed? February 7 th , 2013	

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4), the clients' ISPs (Individual Support Plans) failed to address the clients' identified training needs in regards to meal preparation and for 1 of 4 sampled clients (client #3), the facility failed to address food stealing in the client's plan. Findings include: During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, the following was observed: At 4:20 PM DCS (Direct Care Staff) #12 placed frozen chicken pieces onto a cookie sheet and placed the cookie sheet into the oven to bake. At 4:30 PM DCS #12 pulled a box of frozen chicken out of the freezer, took the tray of chicken out of the oven, added more chicken and placed the tray back in the oven. DCS #12 then took 3 bags of broccoli and cauliflower out of the freezer and placed them on the counter. At 4:45 PM DCS #12 filled a large pot with water, placed it on the stove and turned the burner on. At 5:10	W0227	**W 227 Individual Program Plan** The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. **1. What corrective action will be accomplished?** · Staff will be retrained on ensuring active treatment and the meal preparation process during their team meeting on 1-30-13. · Programming will be put in place for Clients #1, #2, #3, and #4 to increase their independence with meal preparation. · The ISP for Clients #1, #2, #3, and #4 will be updated to include objectives to participate in meal preparation. · Client #3's behavior plan will be revised to include stealing food as a targeted behavior.	02/07/2013

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	PM DCS #12 was taking the chicken out of the oven and dipping up the vegetables from the stove, placing them in bowls and taking them to the table. By 5:30 PM, clients #2, #3, and #4 were observed sitting at the table for their evening meal. During the time the evening meal was being prepared client #1 was sitting or standing at the dining room table watching the staff prepare the meal. Client's #4 was observed in a wheel chair also not observed to assist in the meal preparation. Client #3 was in and out of the kitchen several times throughout the observation. The DCS were not observed to involve client #3 with the evening meal. Client #1's record was reviewed on 12/11/12 at 11 AM. Client #1's ICAP (Individual Comprehensive Assessment Plan) of 9/12/12 indicated client #1 did not know how to mix and cook simple foods. Client #1's ISP of 8/29/12 failed to indicate any objectives to assist client #1 with meal preparation. Client #3's record was reviewed on 12/11/12 at 2:15pm and on 12/12/12 at 1:40pm. Client #3's 8/28/12 ICAP indicated client #3 did not know how to mix and cook simple foods. Client #3's 4/3/12 ISP failed to indicate any objectives to assist client #3 with meal		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and	

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	preparation. Client #4's record was reviewed on 12/11/12 at 1:35pm. Client #4's 9/12/12 ICAP indicated client #4 did not know how to mix and cook simple foods and required hand over hand assistance by staff. Client #4's 9/12/12 ISP failed to indicate any objectives to assist client #4 with meal preparation. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #3, and #4 required assistance with meal preparation and could not independently prepare a simple meal. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated clients #1, #3, and #4 could not independently prepare a meal. The RC indicated client #1, #3, and #4's ISP did not include any training objectives to assist the clients with meal preparation. 2. During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, client #1's, #5's and #7's bedroom closet doors were locked. Client #3 was getting into client #4's closet at which time DCS #13 stated "That's not your stuff" and verbally prompted client #3 away from client #4's closet. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #2, #5, #6 and #7 each had their own small refrigerators in their bedroom closets and each kept their closet		updated as their needs change **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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doors locked. DCS #13 indicated client #3 would steal any food or drinks that were left out and because of this all the clients in the home had to secure their snacks and drinks in their bedrooms to keep client #3 from stealing them. DCS #13 indicated client #4's extra snacks and beverages were locked in the medication room per the client's request in order to secure them away from client #3.

On 12/11/12 from 5:55am until 8:35am, observation and interview were conducted at the group home. Clients #1, #2, #5, #6 and #7 each had their own small refrigerators in their bedroom closets and each kept their closet doors locked. At 6:15am, client #5 stated "We keep them locked. Our snacks and pop are in there. [Client #3] will take others' pop and we keep them locked up." At 7:55am, client #3 opened and closed drawers to the desk where staff work on computer. DCS #6 stated client #3 "was always looking for food to eat." When asked what staff were to do when client #3 looked for food in desks or places outside the kitchen, DCS #6 stated "We just lock all the extra food up so he can't get it."

On 12/11/12 at 2:15pm and on 12/12/12 at 1:40pm, client #3's record was reviewed. Client #3's 8/28/12 ICAP did not identify client #3's food stealing behavior as an identified need. Client #3's 4/3/12 ISP (Individual Support Plan) indicated client #3 had a guardian. Client #3's record indicated a 4/20/12 BSP (Behavior Support Plan) which included the behaviors of anxiety, agitation, Physical Aggression, wandering, and inappropriate food/eating unhealthy snacks. Client #3's BSP did not include his food stealing behavior. Client #3's BSP included the behavior of "Inappropriate food items eating more than one unhealthy snack in a 30 minute period of time from the trash or food someone else is eating."

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	On 12/13/12 at 11am, an interview was conducted with the QMRP/PD (Qualified Mental Retardation Professional/Program Director). The QMRP/PD indicated, client #3 had the behavior of stealing other clients' food and pop then eating it. The QMRP/PD stated the other clients had locked personal refrigerators "because they did not want [client #3] taking their food and pop then eating it." The QMRP/PD stated client #3 did not have this behavior identified "specifically" because "he can't get to the other clients' personal foods if they lock them." 9-3-4(a)			

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W0242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4), the facility failed to ensure the clients' ISPs (Individual Support Plans) included the clients' identified training objectives in regards to bathing for clients #1 and #2, dressing for clients #1 and #3, tooth brushing for clients #1, #2, and #3 and toileting for client #4. Findings include: 1. Client #1's record was reviewed on 12/11/12 at 11 AM. Client #1's ICAP (Individual Comprehensive Assessment Plan) of 9/12/12 indicated client #1 "requires prompts through the entire process" of bathing and "will not do on his own." Client #1's ISP of 8/29/12 indicated client #1 did not understand the importance of keeping himself clean and "requires verbal prompts for oral hygiene including brushing and flossing." Client #1's MAR (Medication Administration	W0242	**W 242 Individual Program Plan** The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. **1. What corrective action will be accomplished?** · Programming will be implemented for Client #1 on bathing, tooth brushing, and flossing. · Programming will be implemented for Client #2 on bathing, dressing and tooth	02/07/2013

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	Record) of December 2012 indicated the staff were to monitor client #1's toothbrushing twice a day. Client #1's ISP did not indicate any objectives to assist client #1 with bathing and toothbrushing. 2. Client #2's record was reviewed on 12/12/12 at 11 AM. Client #2's ICAP of 8/28/12 indicated client #2 required staff assistance "with entire shower process, toothbrushing and getting dressed." Client #2's ISP of 9/7/12 did not indicate any objectives to assist client #2 with bathing, dressing and toothbrushing. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated client #1 required staff prompting and supervision to bathe and brush his teeth. DCS #13 indicated client #2 required physical and verbal assistance to bathe, dress himself and to brush his teeth. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated clients #1 and #2 required staff supervision to bathe and brush their teeth and client #2 required staff assistance to dress himself. The RC indicated client #1's ISP did not include any training objectives to assist client #1 with bathing and toothbrushing and client #2's ISP did not include any training objectives to		brushing. · Programming will be implemented for Client #3 on dressing, wearing clean clothing, and tooth brushing. · Programming will be implemented for Client #4 on toileting independence. · The ISP's for Clients #1, #2, #3, #4 will be updated to include the above mentioned objectives. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change.	

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	assist client #2 with bathing, dressing and toothbrushing.		**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	3. On 12/11/12 at 7:15am, client #3 got out of bed, walked to the medication room, and walked to the kitchen wearing a tee shirt. At 7:55am, client #3 wore the same tee shirt he had slept in and prepared to leave for work. At 7:55am, DCS (Direct Care Staff) #2 was asked if that was the same tee shirt. At 7:55am, DCS #2 prompted client #3 to change his tee shirt which he had slept in and was soiled. At 8:10am, the House Manager (HM) stated client #3 wears the same clothes "sometimes" to bed then will wear to workshop "if we don't watch it." Client #3's record was reviewed on 12/11/12 at 2:15pm and on 12/12/12 at 1:40pm. Client #3's 8/28/12 ICAP indicated client #3 "does fairly well" to dress neatly and did not identify changing a soiled/slept in tee shirt. Client #3's 10/19/12 Dental assessment indicated his teeth were cleaned under Anesthesia. Client #3's ICAP did not assess toothbrushing. Client #3's 4/3/12 ISP did not indicate any objectives to assist client #3 with dressing and toothbrushing. Interview with the RC on 12/13/12 at 4 PM indicated client #3's ISP did not include any training objectives to assist client #3 with dressing and toothbrushing. 4. Client #4's record was reviewed on	W0242	**W 242 Individual Program Plan** The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. **1. What corrective action will be accomplished?** · Programming will be implemented for Client #1 on bathing, tooth brushing, and flossing. · Programming will be implemented for Client #2 on bathing, dressing and tooth brushing. · Programming will be implemented for Client #3 on dressing, wearing clean clothing, and tooth brushing. · Programming will be implemented for Client #4 on toileting independence. · The ISP's for Clients #1,	02/07/2013

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	12/11/12 at 1:35pm. Client #4's 10/18/12 Physician Orders indicated he was prescribed Oxybutynin since 4/2/2009 as a "General Medication" for incontinence. Client #4's 9/12/12 ICAP indicated client #4 "does very well (sic) Uses the toilet at regular times when placed on the toilet or when taken to the bathroom." Client #4's 9/12/12 ISP did not indicate any objectives to assist client #4 with toileting. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated client #4's ISP did not include any training objectives to assist client #4 with toileting. 9-3-4(a)		#2, #3, #4 will be updated to include the above mentioned objectives. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be	

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			implemented. · The residents behavior plans will be reviewed and updated as their needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0304	483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client.	W0304	**W 304 Physical Restraints** Restraints must be designed and used so as not to cause physical injury to the client. **1. What corrective action will be accomplished?** · Staff will be retrained on the HWC restraint on 1-30-13 during their team meeting. · The IDT will meet on 1-30-13 to discuss the continued need for restraint in Client #6's behavior plan and explore ideas on how injuries can be prevented. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on the HWC restraint on 1-30-13 during their team meeting.	02/07/2013

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			· As behavior concerns arise the IDT will meet to address their needs. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on the HWC restraint on 1-30-13 during their team meeting. · As behavior concerns arise the IDT will meet to address their needs. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?**	

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Based on record review and interview, the facility failed to protect 1 of 1 client who was physically restrained (client #6) from injury due to the restraint.

Findings include:

The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's BDDS (Bureau of Developmental Disabilities Services) report of 3/14/12 indicated client #6 became upset, began throwing items and pulling staff's hair. Client #6 "was placed in the standing primary restraint as taught by our Handle with Care program."

Review of the "General Event Report" of 3/14/12 indicated the DCS (Direct Care Staff) restrained client #6 to prevent him from "throwing things." The report indicated client #6 obtained a bruise approximately the size of a quarter on each upper arm. The report indicated client #6 was injured due to the restraint. The report indicated the RC (Residential Coordinator) reviewed the report and indicated the "staff had some difficulty holding him (client #6) in restraint and had to reapply."

Interview with the RC on 12/13/12 at 4

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	PM indicated client #6's injury was due to the restraint. 9-3-5(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. Based on record review and interview, for 2 of 3 sampled clients (clients #1 and #3) who received psychotropic medications, the facility failed to evaluate client #1 and #3's status for an annual decrease or contraindication of psychotropic medication. Findings include: 1. Client #1's record was reviewed on 12/11/12 at 11 AM. Client #1's ISP (Individual Support Plan) of 8/29/12 included a PSP (Psychotropic Service Plan) dated 11/3/12 which indicated client #1 had targeted behaviors of anxiety, agitation, attention seeking, obsessive compulsion, noncompliance, verbal aggression and self-injurious behaviors. Client #1's plan indicated client #1 was being given Paxil to address the client's obsessive compulsive behaviors. Client #1's psychotropic medication reviews of 3/30/11, 9/27/11, 3/26/12 and 9/24/12 indicated the continued use of Luvox 100 milligrams twice a day and Doxepin 10 milligrams a day for depression and anxiety. The medication reviews indicated: 9/24/12 - "Continues to do well." "No	W0316	**W 316 Drug Usage** Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. **1. What corrective action will be accomplished?** · Client #1's next psychiatrist appointment is scheduled for 3-26-13. At that appointment the need for a possible reduction will be discussed with the physician if the client has met the criteria for reduction. · Client #3's next psychiatrist appointment is scheduled for 4-1-13. At that appointment the need for a possible reduction will be discussed with the physician if the client has met the criteria for reduction. · The RC will be retrained on how to write psych consults to provide to the psychiatrist at the scheduled appointments so that an informed decision can be made about the medications at that time.	02/07/2013

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	15G225	A. BUILDING 00 B. WING	01/08/2013

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	request for med changes." 3/26/12 - "Continues to do well with stable behaviors." 9/27/11 - "Continues to do well." "No problems." 3/30/11 - "Continues to do well." No medication changes. Client #1's record and psychotropic medication reviews did not indicate a change or contraindication of change of client #1's psychotropic medication. Client #1's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review. Interview with the RC (Residential Coordinator) on 12/13/12 at 3 PM stated client #1 had not had a medication reduction in the previous year "that I know of." The RC stated since client #1 was "just on antidepressants," client #1 did not need to be considered for an annual medication reduction. 2. A review of client #3's record was completed on 12/11/12 at 2:15pm and on 12/12/12 at 1:40pm. Client #3's 4/3/12 Individual Support Plan (ISP) and 4/2012 BSP (Behavior Support Plan) indicated he had targeted behaviors of agitation, wandering, physical aggression, and inappropriate eating/unhealthy food. Client #3's 10/1/12 and 4/2/12 Psychiatric		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The RC will be retrained on how to write psych consults to provide to the psychiatrist at the scheduled appointments so that an informed decision can be made about the medications at that time. · The IDT will discuss the residents continued need for psychotropic medications prior to their scheduled psychiatric appointment. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The RC will be retrained on how to write psych consults to provide to the psychiatrist at the scheduled appointments so that an informed decision can be made about the medications at that time.	

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	medication reviews indicated the use of Risperdal 0.5mg (milligrams) for anxiety and agitation, and Paxil 40mg for anxiety and agitation. Client #3's Psychological Reviews indicated client #3's behaviors and "no" changes. No behavior rates were available for review. Client #3's 10/1/12 Psychological Review indicated "continues to do well, return 6 months." Client #3's 4/2/12 Psychological Review indicated "continues to do very well, return 6 months." Client #3's 10/22/12 "Clinician Report" indicated a goal "To decrease incidents of agitation, anxiety, rumination, physical aggression, wandering away from staff while in the community, and inappropriate food items." Client #3's clinician report indicated "Criteria for Completion: When data reflects a stabilization of symptoms: reduce physical aggression by 50% within 6 months and by 100% within 1 year, Reduce anxiety/agitation/rumination by 50% within 6 months and 100% within 1 year, the IDT (Interdisciplinary Team) will refer to the prescribing physician for a consideration of a reduction in medication or alternate medication." Client #3's record and psychotropic medication reviews did not indicate a change or contraindication of change of client #3's psychotropic medication. Client #3's record did not indicate the last psychotropic medication change or		· The IDT will discuss the residents continued need for psychotropic medications prior to their scheduled psychiatric appointment. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	contraindication. An interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and Residential Coordinator (RC) was conducted on 12/13/12 at 11:30am. The PD/QMRP indicated no additional information was available for review to determine if client #3's psychotropic medication was evaluated for an annual decrease or if a decrease was contraindicated. The PD/QMRP stated client #3's record indicated client #3 was "stable" for behaviors. 9-3-5(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W0331	**W 331 Nursing Services** The facility must provide clients with nursing services in accordance with their needs. **1. What corrective action will be accomplished?** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · Client #1, #2, #3, #4, #5, #6, and #7 will be placed on programming to follow their diet. · All of the menus prescribed for the clients will be available within the home for staff to follow. · The dietician completed	02/07/2013

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			her quarterly evaluations for the home on 1-24-13. Upon receiving her recommendations, the IDT will review and implement the recommendations accordingly. · Client #7 attended weekly diabetic education classes. His last class was scheduled for 1-23-13. · The MAR's for clients #1, #2 and #7 to ensure that the correct dietary orders were in place. · Staff will be trained on the importance of documentation regarding health care needs (i.e. blood sugars, bowel movements, blood pressures, weight, etc.), how to complete appropriate health care reporting forms accurately, reasons to contact the RC and reporting to the RC/Nurse per MAR and risk plan directives during their staff meeting on 1-30-13. · Client #1 will have his PSA lab drawn before 2-7-13. · The risk plans for Client #1, #2 and #7 will be reviewed and updated as necessary. · The importance of following the physician's orders will be reviewed with the staff and the RC on 1-30-13 during their team meeting.	

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			· The nurse will document any reported concerns about the clients in the Health Notes or GER's when appropriate. · The med charts will be reviewed for all residents to ensure doctor recommendations, required appointments/follow ups and labs are completed as ordered. · Quarterly physicals are completed by the Clients PCP. The next scheduled quarterly physicals for the clients are as follows: o Client #1 2-7-13 o Client #2 2-7-13 o Client #3 2-4-13 o Client #4 2-11-13 o Client #5 2-4-13 o Client #6 2-14-13 o Client #7 2-11-13 **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the	

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			same deficient practice. · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · All of the menus prescribed for the clients will be available within the home for staff to follow. · Staff will be trained on the importance of documentation regarding health care needs (i.e. blood sugars, bowel movements, blood pressures, weight, etc.), how to complete appropriate health care reporting forms accurately, reasons to contact the RC and reporting to the RC/Nurse per MAR and risk plan directives during their staff meeting on 1-30-13. · The importance of following the physician's orders will be reviewed with the staff and the RC on 1-30-13 during their team meeting.	

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			· The nurse will document any reported concerns about the clients in the Health Notes or GER's when appropriate. · The risk plans will be reviewed for all residents and updated as their needs change. · The MAR's for all residents will be reviewed and updated as their needs change. · The med charts will be reviewed for all residents to ensure doctor recommendations, required appointments/follow ups and labs are completed as ordered. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13.	

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			· All of the menus prescribed for the clients will be available within the home for staff to follow. · Staff will be trained on the importance of documentation regarding health care needs (i.e. blood sugars, bowel movements, blood pressures, weight, etc.), how to complete appropriate health care reporting forms accurately, reasons to contact the RC and reporting to the RC/Nurse per MAR and risk plan directives during their staff meeting on 1-30-13. · The importance of following the physician's orders will be reviewed with the staff and the RC on 1-30-13 during their team meeting. · The nurse will document any reported concerns about the clients in the Health Notes or GER's when appropriate. · The risk plans will be reviewed for all residents and updated as their needs change. · The MAR's for all residents will be reviewed and updated as their needs change. · The med charts will be reviewed for all residents to ensure doctor recommendations, required appointments/follow ups and labs are completed as	

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	Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #2) and 1 additional client (#7), the facility nursing services failed to ensure: specific health care plans that included parameters of low and high blood sugar results and when the staff was to notify the nurse were developed and implemented to address client #1's and		ordered. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The nurse will monitor as concerns are reported to her, during her regular audits and through review of health care reports. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	#7's identified health care needs in regards to diabetes; the DCS followed the protocol for taking blood sugars; the DCS were accurately taking client #2's and #7's weights; the DCS notified nursing of medical concerns, the DCS documented the clients' medical information as directed by the doctor and the DCS followed the facility menus. Findings include: During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, clients #1, #2, #3, #4, #5, #6 and #7 were eating their evening meal. The evening meal consisted of oven fried chicken, broccoli/cauliflower mix, mashed potatoes and fruit cocktail with water and sugar free punch. Client #7 was took double portions of everything. While the staff assisted client #7's housemates with filling their plates, client #7 began picking up the bread crumbs of oven fried chicken off of the plate of chicken and eating them. Client #7 then began pulling the skin off of the 2 pieces of chicken he had placed on his plate and began eating that. Client #1 placed a serving of broccoli and cauliflower on his plate but did not eat it. At 6:05 PM everyone was finished eating except client #7 who remained at the table and continued to eat. DCS #12 began clearing the table of the remaining food.			

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	DCS #12 asked client #7 if he wanted the rest of the mashed potatoes and put the remaining potatoes onto client #7's plate. While doing so DCS #12 stated, "You shouldn't eat so much because it will raise your blood sugar." Throughout the evening meal the DCS did not prompt client #7 on appropriate serving sizes. Clients #1, #2, #3, #4, #5, #6 and #7 were not offered bread, margarine or milk during this observation or an equal substitution. The DCS did not offer client #1 a substitution for the broccoli/cauliflower mix he did not eat. During observations at the group home on 12/11/12 from 5:55 am until 8:35 am, client #7 ate a banana, milk, juice, cold cereal, toast, and two bags of microwave popcorn. At 7:50 am client #7 ate a bag of popcorn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From 10:35am until 12noon, client #7 walked			

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	into and out of the workshop area, the break area and from one classroom to the next classroom. From 10:35am until 12noon client #7 fixed his own bag of microwave popcorn and consumed it while he walked throughout the workshop. Client #7 walked into and out of offices in the front area of the workshop and the lobby area. During the period from 10:35am until 12noon client #7 was not monitored by the workshop staff to prompt him to activity or monitor client #7's location within the workshop. At 11:25am, client #7 stated "I eat about 4 to 5 bags of popcorn when I'm here a day." At 11:25am, client #7's Workshop Supervisor (WKS) indicated client #7 did eat 4 to 5 bags of microwave popcorn a day when he attended workshop. Client #7 was waiting for the facility staff to come and check client #7's blood sugar. At 12:10pm, client #7 had his blood sugar check and it was 338. The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Report of 5/24/12 indicated while the DCS was preparing client #7's insulin, client #7 grabbed the needle from the DCS's hands, rolled the Humalog up to 60 units and injected himself with the 60 units of Humalog insulin. The report indicated the DCS called the RC (Residential Coordinator),			

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	the RC called the nurse and the nurse told the RC to call the doctor and the doctor instructed the RC to monitor the client's blood sugar. The facility's menus were reviewed on 12/10/12 at 6 PM. The only menu provided for review being used in the group home was the facility's Fall/Winter 1800 KCAL(kilocalorie's) menu dated 10/7/09. The menu indicated the evening meal on 12/10/12 the clients were to have: __3 ounces of meatloaf __1/2 cup of mashed potatoes or 1/2 cup of cooked corn __1 cup of green beans __1 slice of bread with 1 teaspoon of margarine __1/2 cup of mandarin oranges __1 cup of water __1 cup of skim or 1/2 % milk __8 to 12 ounces of sugar free punch Review of the Food Substitution Record of December 2012 on 12/10/12 at 6 PM indicated the staff had substituted chicken for meatloaf and green beans for broccoli/cauliflower. The record indicated the reason for the substitution was the "guys choice." The record failed to include the substitution of the mandarin oranges for the fruit cocktail.			

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	Client #1's record was reviewed on 12/11/12 at 11 AM. The client's record indicated the client had a diagnosis of, but not limited to, Insulin dependent Diabetes. __Client #1's 8/29/12 ISP (Individual Support Plan) indicated client #1 "depends on staff to make sure healthy choices are available for him to help him maintain his blood sugar levels." Client #1's December MAR (Medication Administration Record) indicated the client was on a "Renal Calorie Diet" and could have second helpings of non-starchy vegetables and protein. The MAR also indicated client #1 was on a "Regular - low fat no concentrated sweets" diet. The client's quarterly nutrition review of 2/6/12 indicated the dietician had altered the 1800 KCAL menu for client #1 to lower his potassium levels. The dietician indicated she had provided an "1800 KCAL, low potassium menu" to assist client #1 with his renal diet. The client's nutrition review of 5/8/12 indicated the client's diet was not on the physician's orders as previously requested and the client may not be following the diet as recommended. The client's record failed to indicate nursing services had addressed the change of diet by the dietician at the time of the recommendation. __Client #1's 2012 MARs indicated client			

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	#1 was taking Glimepiride 4 milligrams (an oral anti-diabetic drug) a day as well as Humalog Insulin 10 units and Lantus 12 units every day. __ The MAR indicated client #1 was to have his blood sugar taken twice a day and if the client's blood sugar was below 100 or over 250, the DCS were to notify the RC. The MAR indicated client #1 was to have his BP (blood pressure) taken weekly and to be weighed weekly. ____Client #1's Heath Care Report for 12/1/12 through 12/12/12 indicated client #1's blood sugar was below 100 on December 1, 2, 3, 6, 8 and 10. The report indicated the client's blood sugar was 251 on 12/8/12. The report indicated the client was not fasting for 19 of the 21 blood sugars taken and for 2 of the results, the DCS failed to document if the client was fasting or not. ____Client #1's Heath Care Report for 11/1/12 through 11/30/12 indicated client #1's blood sugar was below 100 on November 5 , 6, 7, 12, 14, 15, 20, 22, 28 and 29. The report indicated the client's blood sugar was 251 on 11/4/12 and 11/30/12. The report indicated the client was not fasting for any of the blood sugars taken in November. __Client #1's record indicated the client's last PSA (Prostate Specific Antigen), a screening test for prostate cancer, was last done on 11/10/10.			

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	__Client #1's record did not indicate the facility nurse was notified when client #1's blood sugars were elevated. Client #1's record did not indicate a nursing plan of care in regards to client #1's medical issues, when the staff are to notify the nurse and of what. Client #1's record did not indicate a nurse had reviewed client #1's medical data for September, October, November and December 2012. Client #2's record was reviewed on 12/12/12 at 11 AM. Client #2's nutritional assessment of 5/8/12 indicated client #2 weighed 111 pounds with an average weight range of 110 to 140 pounds. The assessment indicated the dietician had "some concern with gain and then loss? Appears to have gained 20# (pounds) between Feb (February) and March and then lost 16# between March and April? CIB (Carnation Instant Breakfast - a nutritional supplement) was added earlier this year at BID (twice a day) and then increased to TID (three times a day) 4/12" in order to maintain his weight. The dietician indicated the DCS were to encourage client #2 to eat 3 meals a day and to substitute foods he didn't like. Client #2's record did not indicate nursing services had addressed the dietician's concerns. Client #7's record was reviewed on			

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	12/12/12 at 2 PM. Client #7's record indicated diagnose of, but not limited to, Type II Insulin Dependent Diabetic, Diabetic Neuropathy (damage to nerves in the body that occurs due to high blood sugar levels from diabetes), Obesity, Chronic Diastolic Heart Failure, Epilepsy, BPH (enlarged prostrate), Sleep Apnea. Client #7's ISP of 4/3/12 indicated the client was "quite obese" and was diabetic "with increasing problems with controlling his high blood sugars." __Client #7's quarterly physician reviews for 2012 indicated client #7 was to have his blood sugar taken TID (3 times a day) "before meals." __Client #7's 2012 MARs indicated client #7 was taking Glipizide 10 milligrams and Metformin 2000 milligrams (oral anti-diabetic drugs) a day as well as Lantus Insulin 60 units and Humalog Insulin 16 units three times a day with extra coverage of Humalog for blood sugars above 160 for his diabetes. The MAR indicated client #7 was to have his blood sugar taken "3 times daily before meals" and if the client's blood sugar was below 100 or over 250, the DCS were to notify the RC. The MARs indicated client #7 was to have his BP (blood pressure) taken daily and if the client's BP was less than 100/60 or greater than 140/90, the DCS were to notify the RC. The MAR indicated the client was to be weighed			

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	weekly. __Client #7's Health Care Report for 12/1/12 through 12/12/12 indicated client #7's blood sugars were over 160 - 19 out of 20 times taken, 14 were over 200 and 2 were over 300. The report indicated the client was not having his blood sugar taken 3 times a day as the physician requested as the DCS had not documented 17 of the 36 times the client was to have his blood sugar tested. The report indicated the client was not fasting for 7 of the blood sugar tests and for 7 of the results, the DCS failed to document if the client was fasting or not. The report indicated on 12/9/12 client #7's BP was 156/102. __Client #7's Health Care Report for 11/1/12 through 11/30/12 indicated the client was not having his blood sugar taken 3 times a day as the physician requested as the DCS had not documented 53 of the 90 times the client was to have his blood sugars tested. Of the 37 times the DCS did test client #7's blood sugars, 34 were over 160. Of those 34 tests, 15 were over 200, 8 were over 300 and 6 were over 400. The report indicated the client was not fasting for 14 of the blood sugar tests and for 10 of the results, the DCS failed to document if the client was fasting or not. The report indicated on 11/15/12 client #7's BP was 141/103. The report indicated client #7's weight was			

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	301 pounds for 3 weeks in a row without change. __Client #7's Health Care Report for 10/1/12 through 10/31/12 indicated the client was not having his blood sugar taken 3 times a day as the physician requested as the DCS had not documented 31 of the 93 times the client was to have his blood sugars tested. Of the 31 times the DCS did test client #7's blood sugars, 51 were over 160. Of those 34 tests, 35 were over 200, 13 were over 300. The report indicated the client was not fasting for 22 of the blood sugar tests and for 30 of the results, the DCS failed to document if the client was fasting or not. The report indicated client #7's weight was 290 pounds for 5 weeks in a row without change. __Client #7's Health Care Report for 9/1/12 through 9/30/12 indicated the client was not having his blood sugar taken 3 times a day as the physician requested as the DCS had not documented 23 of the 90 times the client was to have his blood sugars tested. Of the 67 times the DCS did test client #7's blood sugars, 63 were over 160. Of those 63 tests, 39 were over 200, 12 were over 300 and 2 were over 400. The report indicated the client was not fasting for 15 of the blood sugar tests and for 46 of the results, the DCS failed to document if the client was fasting or not. The report indicated on			

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	9/15/12 client #7's BP was 141/103. The report indicated client #7's weight was 296 pounds for 4 weeks in a row without change. The report indicated the RC did not review the September data until 10/22/12. The report indicated the facility nurse did not review the September data until 10/23/12. The nurse indicated "Numerous days of missing BM (bowel movement) tracking/skin assessments, but no reported issues this month." __Client #7's record did not indicate the facility nurse was notified when client #7's blood sugars and blood pressures were elevated. Client #7's record did not indicate a nursing plan of care in regards to client #7's medical issues that included when the staff are to notify the nurse and of what. Interview with client #1 on 12/10/12 at 6:25 PM indicated he did not eat his broccoli/cauliflower mixture because he didn't like it. When asked if the DCS had offered him anything in place of the broccoli/cauliflower mixture, the client stated, "No." The client indicated he would have liked to have something else in place of the vegetables that were offered. Interview with DCS #14 and #12 on 12/10/12 at 6 PM indicated DCS #12 did not know which menu he was to be			

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	following in the preparation of the evening meal. DCS #14 indicated because a family member had brought food into the home for a previous meal and due to lack of food in the home and the need to go shopping, the Monday evening menu had been substituted for a Sunday lunch. DCS #12 indicated the Fall/Winter 1800 KCAL menu was the only menu in the home and the one that was followed for clients #1, #2, #3, #4, #5, #6 and #7. Interview with the RC on 12/13/12 at 4 PM indicated client #7 had a history of non compliance with his diet and medications, "But it's his right to eat what he wants." The RC stated the DCS were to "encourage" the clients to follow the menu, but if the clients chose not to eat the food offered, "there's nothing we can do." The RC indicated he had talked to the DCS about documenting the medical data at the staff meetings. The RC stated, "I guess I'm just going to have to start writing them up." The RC indicated client #7 was on 15 minute checks due to his brittle diabetes and his history of going AWOL (absence without leave). Interview with the facility LPN (Licensed Practical Nurse) on 12/13/12 at 9:30 AM indicated she had not completed a physical assessment on clients #1, #2, #3, #4, #5, #6 and #7. The LPN indicated she			

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	had not received any calls in regards to clients #1 or #7 in regards to any health concerns. The LPN indicated she had made no documentation in clients #1's and #7's records. The LPN indicated the previous nurse had quit the facility a couple of months earlier and she was only trying to fill in until the facility could hire a permanent nurse. The LPN indicated clients #1 and #7 did have Diabetic protocols in their records but neither were personalized to each client's specific medical issues and neither indicated the parameters of information nursing was to be notified with. The LPN indicated the facility protocol was to call the RC if there was a problem and then the RC would notify the nurse. The LPN indicated she had not received any calls from the RC of any issues in regards to clients #1 and #7. The LPN indicated all scheduled blood sugars were to be fasting and taken prior to the clients eating. The LPN indicated the DCS were to follow each clients' diet as the physicians had ordered. The LPN indicated the facility protocol was to have a yearly PSA on all males 50 and older. The LPN indicated client #1 had not had a PSA since 2010. 9-3-6(a)			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 2 of 25 medications observed being administered, the facility failed to ensure all medications were administered without error to clients #4 and #6. Findings include: 1. During observation on 12/11/12 at 7am, client #4 was eating breakfast of CIB (Carnation Instant Breakfast), cold cereal and toast at the dining room table. At 7:35am, DCS (Direct Care Staff) #5 administered client #4's medication from a medication blister package which indicated "Gemfibrozil 600mg (milligrams) 1 tablet twice daily 1/2 hrs. (one half hour) before meal" for Hypercholestremia. At 7:40am, client #4's MAR (Medication Administration Record indicated "Gemfibrozil 600mg (milligrams) 1 tablet twice daily 1/2 hrs. (one half hour) before meal" for Hypercholestremia (high cholesterol). At 7:40am, DCS #5 indicated the medication administered to client #4 was the facility's 7am medication pass.	W0369	**W 369 Drug Administration** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. **1. What corrective action will be accomplished?** · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13. · A medication practicum will be done with Staff #5 by 2-7-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice.	02/07/2013

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	2. During observation at the group home on 12/11/12 from 6:15am until 6:40am, client #6 consumed three (3) whole bananas. At 6:50am, client #6 consumed his breakfast of toast, milk, and cold cereal. At 7:15am, DCS #5 requested client #6 come to the medication room. DCS #5 administered client #6's "Levothroxine 112mcg (micrograms) (Synthroid) give 1 tablet orally once a day half an hour before food" for thyroid. At 7:40am, DCS #5 indicated client #6's medications were given the 7am medication pass. Interview with the facility nurse on 12/13/12 at 9:30 AM indicated all medications were to be given as the physician had prescribed and as directed on the MAR. The facility nurse indicated the DCS were to triple check the medication with the physician's orders, the MAR and the pill pack to ensure all three match. The facility nurse indicated the DCS should have notified nursing of the discrepancy of not giving client #4 and #6's medications until after they had eaten. 9-3-6(a)		· Random medication practicums will be completed with staff to ensure that they are following the proper med pass procedures and the prescribed doctor's orders. · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Random medication practicums will be completed with staff to ensure that they are following the proper med pass procedures and the prescribed doctor's orders. · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?**	

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			· The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview, for 1 of 1 client (client #5) who had medication administered at the workshop by the facility staff, the facility failed to ensure medication was kept secure. Findings include: On 12/11/12 at 12noon, the facility's Direct Care Staff (DCS) #3 entered the workshop through the front door where client #7 sat at a table in the front lobby area. At 12noon, DCS #3 set down a clear plastic unlocked box on the table in front of client #7 and walked onto the workshop floor area. DCS #3 left the unlocked clear plastic box on the table and out of DCS #3's view. Client #7's insulin medication (for Diabetes) pen and lancets were visibly observed inside the clear plastic box. At 12:10pm, DCS #3 returned to the area where she had left the unsecured insulin medication pen and lancets. At 12:20pm, DCS #3 administered client #7's insulin medication. On 12/12/12 at 10:55am, an interview with the QMRP/PD (Qualified Mental Retardation Professional/Program Director) and the RC (Residential	W0381	**W 381 Drug Storage and Recordkeeping** The facility must store drugs under proper conditions of security. **1. What corrective action will be accomplished?** · Note- in the description of how the standard was not met the observation and interview references Client #5. In the findings section Client #7 is referenced. The incident described happened with Client #7, not Client #5. · Staff will be retrained on the medication administration pass procedures and the importance of keeping medications secured on 1-30-13. · A medication practicum will be done with Staff #3 by 2-7-13. · A box that can be secured will be purchased for Client #7's insulin. This box will be used when the insulin is taken on outings and to workshop.	02/07/2013

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	Coordinator) was conducted. The QMRP/PD and the RC both indicated client #7's insulin medication should have been secured and was not once the staff walked away from the unsecured medication box. 9-3-6(a)		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on the medication administration pass procedures and the importance of keeping medications secured on 1-30-13. · A medication practicum will be done with Staff #3 by 2-7-13. · A box that can be secured will be purchased for Client #7's insulin. This box will be used when the insulin is taken on outings and to workshop. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff will be retrained on the medication administration pass procedures and the importance of keeping medications secured on 1-30-13. · A medication practicum will be done with Staff #3 by 2-7-13.	

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			· A box that can be secured will be purchased for medications that need to be transported. This box will be used when the insulin is taken on outings and to workshop. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, record review, and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), to ensure the temperature of the water did not exceed 110 degrees Fahrenheit. Findings include: During observations at the group home on 12/10/12 between 4 PM and 7 PM, the temperature of the water was observed to be too hot to keep this surveyor's hands in it for routine hand washing. Steam was rising from the sink. The water temperature was taken at 6:15 PM in the north bathroom at the tub and was found to be 128 degrees Fahrenheit. The water temperature was taken at 6:20 PM in the south bathroom at the shower and was found to be 128.5 degrees Fahrenheit. During observations at the group home on 12/11/12 from 5:55am to 8:35am, the temperature of the water was measured with Direct Care Staff (DCS) #5 and DCS	W0426	**W 426 Client Bathrooms** The facility must, in areas of the facility where clients who have not been trained to regulate the water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. **1. What corrective action will be accomplished?** · The water temperature in the home has been adjusted back to 110 degrees Fahrenheit. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on	02/07/2013

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	15G225	A. BUILDING 00 B. WING	01/08/2013

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	#6 as follows: -At 6am, the kitchen sink was 126.9 degrees Fahrenheit. -At 6am, bathroom #1 was 132.6 degrees Fahrenheit. -At 6:05am, the handsink in the medication room was 132.7 degrees Fahrenheit. On 12/11/12 at 12:05pm, the QDP (Qualified Disabilities Professional) was interviewed. The QDP stated clients #1, #2, #3, #4, #5, #6, and #7 "did not recognize the risks of hot water." The QDP indicated monitoring of the group home water temperature log was completed by the overnight staff and the water temperature was not to exceed 110 degrees Fahrenheit.		1-30-13. · Water temperature assessments will be completed with Client #1, #2, #3, #4, #5, #6 and #7. (Note there was not a client #8 at the time of the survey). · The IPOP assessments will be updated to reflect Client's #1, #2, #3, #4, #5, #6, and #7's abilities to regulate water temperatures. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on 1-30-13.	

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			· The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on 1-30-13. · The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not**	

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	Client #1's record was reviewed on 12/11/12 at 11 AM. The client's record did not indicate client #1 could adjust the water temperature within the group home. Client #2's record was reviewed on 12/12/12 at 11 AM. The client's record did not indicate client #2 could adjust the water temperature within the group home. Client #3's record was reviewed on 12/11/12 at 2:15PM. The client's record did not indicate client #3 could adjust the water temperature within the group home. Client #4's record was reviewed on		**recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. · The Maintenance Director will also monitor as he completes his checks. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	12/12/12 at 1:35PM. The client's record did not indicate client #4 could adjust the water temperature within the group home. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:30 PM indicated the temperature of the water in the group home was not to be above 110 degrees Fahrenheit. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated the temperature of the water in the group home was not to exceed 110 degrees Fahrenheit. 9-3-7(a)			

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W0429	483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. Based on observation and interview, for 3 of 7 clients (clients #3, #4, and #5) living in the group home, the facility failed to maintain heat above 68 degrees F (Fahrenheit) inside the client bedrooms. Findings include: On 12/11/12 at 5:55am, observation was completed at the group home. During the observation clients #3, #4, and #5's bedroom doors were propped open. At 6am, DCS (Direct Care Staff) #5 and DCS #6 both indicated the doors were propped open to allow heat to get into the bedrooms. At 6:05am, client #5 stated "My room is cold," and the air temperature read 62 degrees Fahrenheit. At 6:25am, client #3 and #4's shared bedroom air temperature was 60 degrees Fahrenheit. At 6:30am, client #4 stated his bedroom "was always cold." Client #4 stated "You can see your breath." Client #4's bedroom door was propped open to the hallway. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated the temperature of client #3, #4, and #5's bedrooms was cold. The PS indicated she	W0429	**W 429 Heating and Ventilation** The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. **1. What corrective action will be accomplished?** · A service call was completed by the Heating and Cooling company used by Occazio on 1-22-13. It was found during the service call that the vents in Client #3, #4, and #5's bedrooms were closed. · The vents have now been opened. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The RC and/or DSA will	02/07/2013

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	was not aware of this. 9-3-7(a)		ensure that the vents remain open so that a proper temperature can be maintained within the rooms. · Temperature concerns will be reported to the Maintenance Director. · The Heating and Cooling equipment within the home will be serviced on a regular basis to ensure that it is operating properly. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The RC and/or DSA will ensure that the vents remain open so that a proper temperature can be maintained within the rooms. · Temperature concerns will be reported to the Maintenance Director. · The Heating and Cooling equipment within the home will be serviced on a regular basis to ensure that it is operating properly. **4. How will the corrective**	

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			action be monitored to ensure the deficient practice will not recur? · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. · The Maintenance Director will also monitor as he completes his checks. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #3 and #4) who had adaptive equipment prescribed, the facility failed to teach and encourage client #3 to wear his prescribed eye glasses and failed to ensure client #4's wheelchair was in good repair. Findings include: 1. During observations at the group home on 12/10/12 between 4 PM and 7 PM and on 12/11/12 from 5:55am until 8:35am, client #3 was not wearing any eyeglasses. During this time period the DCS (Direct Care Staff) #5 and DCS #6 did not prompt client #3 to wear his glasses. Client #3's record was reviewed on 12/11/12 at 2:15pm, and on 12/12/12 at 1:40pm. Client #3's 11/1/11 vision assessment indicated client #3 had prescribed eye glasses and a recommendation to wear them during waking hours. Client #3's 4/3/12 ISP (Individual Support Plan) did not indicate a goal/objective to wear his glasses.	W0436	**W 436 Space and Equipment** The facility must furnish, maintain in food repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. **1. What corrective action will be accomplished?** · Client #3 will be put on programming to encourage him to wear his eye glasses. · Client #3's ISP will be updated to reflect the need to wear his eye glasses. · Staff will be retrained on 1-30-13 during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment.	02/07/2013

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	On 12/13/12 at 11am, an interview was conducted with the QDP (Qualified Developmental Professional). The QDP indicated client #3 had prescribed eye glasses. The QDP indicated client #3 did not have a formal goal to wear his eye glasses. The QDP indicated client #3 should have been taught and encouraged to wear his prescribed eyeglasses. 2. During observations at the group home on 12/10/12 between 4 PM and 7 PM and on 12/11/12 from 5:55am until 8:35am, client #4 sat in his wheelchair and one of the two arm rests was held in place with duct tape. On 12/11/12 at 1:35pm, client #4's record was reviewed. Client #4's 9/12/12 ISP indicated he used a wheelchair for ambulation. On 12/13/12 at 11am, an interview with the QDP was conducted. The QDP indicated client #4's wheelchair had duct tape which held the arm rest in place. The QDP indicated he was not aware of the needed repair to client #4's wheelchair. 9-3-7(a)		· Client #4 has a new wheelchair that has been ordered. It should arrive before 2-7-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on 1-30-13 during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment. · The residents IPOP assessments will be reviewed and updated as their needs change. · Programming will be implemented based on the residents assessments and as their needs change. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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			practice does not recur: · Staff will be retrained on 1-30-13 during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment. · The residents IPOP assessments will be reviewed and updated as their needs change. · Programming will be implemented based on the residents assessments and as their needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6, and #7), by not ensuring an evacuation drill was conducted at least every 90 days for the day shift (7 AM - 3 PM) during 2012. Findings include: The facility's evacuation drills were reviewed on 12/12/12 at 1 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7 for the period between 4/14/12 at 2pm and 10/13/12 at 2pm, for the day shift personnel. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7. 9-3-7(a)	W0440	**W 440 Evacuation Drills** The facility must hold evacuation drills at least quarterly for each shift of personnel. **1. What corrective action will be accomplished?** · A day shift drill will be run by 2-7-13. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 1-30-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice.	02/07/2013

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			· The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 1-30-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 1-30-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the	

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			home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 3 additional clients (#5, #6 and #7), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu and provided client substitutions for food not eaten. Findings include: During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, clients #1, #2, #3, #4, #5, #6 and #7 were eating their evening meal. The evening meal consisted of oven fried chicken, broccoli/cauliflower mix, mashed potatoes and fruit cocktail with water and sugar free punch. Client #7 took double portions of everything. While the staff assisted client #7's housemates with filling their plates, client #7 began picking up the breading crumbs of oven fried chicken off of the plate of chicken and eating them. Client #7 then began pulling the skin off of the 2 pieces of chicken he had placed on his plate and began eating that. Client #1 placed a serving of broccoli and cauliflower on his plate but did not it. At 6:05 PM clients #1, #2, #3,	W0460	**W 460 Food and Nutrition** Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets. **1. What corrective action will be accomplished?** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · Client #1, #2, #3, #4, #5, #6, and #7 will be placed on programming to follow their diet. · All of the menus prescribed for the clients will be available within the home for staff to follow.	02/07/2013

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	#4, #5 and #6 had eaten their meals and left the table. Client #7 remained at the table and continued to eat. DCS #12 began clearing the table of the remaining food. DCS #12 asked client #7 if he wanted the rest of the mashed potatoes and put the remaining mashed potatoes onto client #7's plate. While doing so DCS #12 stated, "You shouldn't eat so much because it will raise your blood sugar." Throughout the evening meal the DCS did not prompt client #7 on appropriate serving sizes. Clients #1, #2, #3, #4, #5, #6 and #7 were not offered bread, margarine or milk during this observation or an equal substitution. The DCS did not offer client #1 a substitution for the broccoli/cauliflower mix he did not eat. On 12/11/12 from 5:55am until 8:35am, client #7 was observed at the group home. Client #7 consumed his breakfast of a banana, milk, juice, cold cereal, toast, and two bags of microwave popcorn. At 7:55am, Direct Care Staff #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until		· The dietician completed her quarterly evaluations for the home on 1-24-13. Upon receiving her recommendations, the IDT will review and implement the recommendations accordingly. · Client #7 attended weekly diabetic education classes. His last class was scheduled for 1-23-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13.	

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	15G225	A. BUILDING 00 B. WING	01/08/2013

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	12:20pm, observations and interviews were completed at the workshop. From 10:35am until 12noon, client #7 walked into and out of the workshop area, the break area and from one classroom to the next classroom. From 10:35am until 12noon client #7 fixed his own bag of microwave popcorn and consumed it while he walked throughout the workshop. Client #7 walked into and out of offices in the front area of the workshop and the lobby area. At 11:25am, client #7 stated "I eat about 4 to 5 bags of popcorn when I'm here a day." At 11:25am, client #7's Workshop Supervisor (WKS) indicated client #7 did eat 4 to 5 bags of microwave popcorn when he attended workshop a day" and client #7 was waiting for the facility staff to come and check client #7's blood sugar. WKS stated "We check for [client #7's] location every once in a while. If we have not seen him walking around." At 12:10pm, client #7 had his blood sugar check and it was 338. The facility's menus were reviewed on 12/10/12 at 6 PM. The only menu provided for review being used in the group home was the facility's Fall/Winter 1800 KCAL(kilocalorie's) menu dated 10/7/09. The menu indicated for the evening meal on 12/10/12 the clients were to have:		· All of the menus prescribed for the clients will be available within the home for staff to follow. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · All of the menus prescribed for the clients will be available within the home for staff to follow. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the	

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	__3 ounces of meatloaf __1/2 cup of mashed potatoes or 1/2 cup of cooked corn __1 cup of green beans __1 slice of bread with 1 teaspoon of margarine __1/2 cup of mandarin oranges __1 cup of water __1 cup of skim or 1/2 % milk __8 to 12 ounces of sugar free punch The menu indicated the morning meal on 12/11/12 the clients were to have: __1/2 cup of apple juice __1/2 cup of scrambled eggs __2 slices of whole wheat toast with 1 teaspoon of margarine and 1 teaspoon of sugar free jelly __1 cup of water __1 cup of skim or 1/2 % milk Review of the Food Substitution Record of December 2012 on 12/10/12 at 6 PM indicated the staff had substituted chicken for meatloaf and green beans for broccoli/cauliflower. The record indicated the reason for the substitution was the "guys choice." The record failed to include the substitution of the mandarin oranges for the fruit cocktail. Client #1's record was reviewed on 12/11/12 at 11 AM. The client's 8/29/12 ISP (Individual Support Plan) indicated		home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	the client had a diagnosis of, but not limited to, Insulin dependent Diabetes. Client #1's ISP indicated client #1 "depends on staff to make sure healthy choices are available for him to help him maintain his blood sugar levels." Client #1's December MAR (Medication Administration Record) indicated the client was on a "Renal Calorie Diet" and could have second helpings of non-starchy vegetables and protein. The MAR also indicated client #1 was on a "Regular - low fat no concentrated sweets" diet. The client's quarterly nutrition review of 2/6/12 indicated the dietician had altered the 1800 KCAL menu for client #1 to lower his potassium levels. The dietician indicated she had provided an "1800 KCAL, low potassium menu" to assist client #1 with his renal diet. Review of the facility menus did not indicate a low potassium menu for client #1. Client #7's record was reviewed on 12/12/12 at 2 PM. Client #7's ISP of 4/3/12 indicated the client was "quite obese" and was diabetic "with increasing problems with controlling his high blood sugars." The client's Heath Care Reports for 2012 indicate the client was to follow a diabetic diet. The November 2012 Health Care Report indicated client #7 weighed 301 pounds.			

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	Interview with client #1 on 12/10/12 at 6:25 PM indicated he did not eat his broccoli/cauliflower mixture, because he didn't like it. When asked if the DCS had offered him anything in place of the broccoli/cauliflower mixture the client stated, "No." The client indicated he would have liked to have something else in place of the vegetables that were offered. Interview with DCS #14 and #12 on 12/10/12 at 6 PM indicated DCS #12 did not know which menu he was to be following in the preparation of the evening meal. DCS #14 indicated because a family member had brought food into the home for a previous meal and due to lack of food in the home and the need to go shopping, the Monday evening menu had been substituted for a Sunday lunch. DCS #12 indicated the Fall/Winter 1800 KCAL menu was the only menu in the home and the one that was followed for clients #1, #2, #3, #4, #5, #6 and #7. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated client #7 had a history of non compliance with his diet, "But it's his right to eat what he wants." The RC stated the DCS were to "encourage" the clients to follow the menu, but if the clients			

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	chose not to eat the food offered, "there's nothing we can do." Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated the DCS are to offer all of the items on the menu or to provide a like substitute for the food not offered. 9-3-8(a)			

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W0488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.	W0488	**W 488 Dining Areas and Service** The facility must assure that each client eats in a manner consistent with his or her developmental level. **1. What corrective action will be accomplished?** · Staff will be retrained on ensuring active treatment and the meal preparation process during their team meeting on 1-30-13. · \Programming will be put in place for Clients #1, #2, #3, and #4 to increase their independence with meal preparation. · The ISP for Clients #1, #2, #3, and #4 will be updated to include objectives to participate in meal preparation. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	02/07/2013

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			· All residents have the potential to be affected by the same deficient practice. · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · All of the menus prescribed for the clients will be available within the home for staff to follow. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans.	

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	Based on observation, interview and record review, the facility failed to assure 4 of 4 sampled clients (clients #1, #2, #3 and #4) assisted in their meal preparation.		· Staff will be retrained on Client #1, #2, #3, #4, #5, #6, and #7's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 1-30-13. · All of the menus prescribed for the clients will be available within the home for staff to follow. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	Findings include: During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, the evening meal of pre-baked oven chicken, broccoli with cauliflower, mashed potatoes and fruit cocktail was prepared by DCS (Direct Care Staff) #11 and #12. At 5:30 PM, clients #1, #2, #3 and #4 were sitting at the table for their evening meal. During the time the evening meal was being prepared client #1 was sitting or standing at the dining room table watching the staff prepare the evening meal. Clients #2 and #4 were sitting in wheel chairs at or near the dining room table and not involved in the meal preparation. Client #3 was in and out of the kitchen several times throughout the observation. The DCS #11 and #12 did not involve clients #1, #2, #3 and #4 with the evening meal preparation or to provide them training in regards to food preparation. Client #1's record was reviewed on 12/11/12 at 11 AM. Client #1's ICAP (Individual Comprehensive Assessment Plan) of 9/12/12 indicated client #1 did not know how to mix and cook simple foods. Client #2's record was reviewed on 12/12/12 at 11 AM. Client #2's ICAP of			

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	8/28/12 indicated client #2 required staff assistance to mix and cook simple foods. Client #3's record was reviewed on 12/11/12 at 2:15pm and on 12/12/12 at 1:40pm. Client #3's 8/28/12 ICAP indicated client #3 did not know how to mix and cook simple foods. Client #4's record was reviewed on 12/11/12 at 1:35pm. Client #4's 9/12/12 ICAP indicated client #4 did not know how to mix and cook simple foods and required hand over hand assistance by staff. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #2, #3 and #4 required assistance with meal preparation and could not independently prepare a simple meal. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated clients #1 and #2 could not of independently prepare a meal. The RC indicated the DCS were to involve the clients with their meal preparations. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated the DCS are to offer all clients formal and informal training at every available			

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